Kansas Medical Assistance Program	Amerigroup	Sunflower	UnitedHealthcare
PA Phone 800-933-6593	PA Pharmacy Phone 800-454-3730	PA Pharmacy Phone 877-397-9526	PA Pharmacy Phone 800-310-6826
PA Pharmacy Fax 800-913-2229	PA Pharmacy Fax 844-512-8999	PA Pharmacy Fax 866-399-0929	PA Pharmacy Fax 866-940-7328

ANTIDEPRESSANT PRIOR AUTHORIZATION FORM

Complete form in its entirety and fax to the appropriate plan's PA department.
For questions, please call the pharmacy helpdesk specific to the member's plan.

MEMBER INFORMATION		
Name:	Medicaid ID:	
Date of Birth:	Gender:	

PRESCRIBER INFORMATION		
Name:	Medicaid ID:	
NPI:	Phone:	Fax:
Address:	City, State, Zip Code:	

The following medications require Prior Authorization (PA). Medications requiring PA may have to meet clinical **and** Non-Preferred PA criteria before the claim may be considered for payment.

Please provide the required data for the specific drug being requested. Below is a list of links you may find helpful in determining the required information:

- Clinical PA criteria: http://www.kdheks.gov/hcf/pharmacy/pa_criteria.htm
- KS Preferred Drug List (PDL): http://www.kdheks.gov/hcf/pharmacy/download/PDLList.pdf
- Non-Preferred, PA Required PDL criteria: http://www.kdheks.gov/hcf/pharmacy/download/NonPreferred_PA_Criteria_for_PDL_Drugs.pdf

Note: Any area not filled out will be considered not applicable to this PA & may affect the outcome of this request.

Instructions to complete this form:

1. Complete **the Member/Prescriber Information** portion above and **Sections I and II** for **ALL** requests
2. Complete **Section III** if this request requires a **peer-to-peer review**.
3. Complete **Section IV** if this request is a **renewal.**
4. Complete **Section V** if the requested medication is also a **non-preferred medication** on the Kansas Medicaid PDL.
5. Prescriber - **Sign and date** the form prior to submission.

SECTION I: MEDICATION REQUESTED

Name of medication requested: _____

NDC	Strength	Dosage Form	Quantity	Directions for Use

SECTION II: CLINICAL INFORMATION – For ALL Requests

1. Is this a new or renewal request for this medication?
   - ☐ New
   - ☐ Renewal – Proceed to section IV.

MULTIPLE CONCURRENT USE:

1. For patients < 13 years of age, is the patient receiving 2 or more different antidepressants concurrently for greater than 60 days? ☐ YES ☐ NO ☐ Patient ≥ 13 years old
   - If **yes**, written peer-to-peer review is required. **Please complete section III.**
2. For patients ≥ 13 years of age, is the patient receiving 3 or more different antidepressants concurrently for greater than 60 days? ☐ YES ☐ NO ☐ Patient < 13 years old
   - If **yes**, written peer-to-peer review is required. **Please complete section III.**
3. For all ages, is the patient receiving 2 or more different SSRIs (table 1) concurrently for greater than 60 days? ☐ YES ☐ NO
   - If **yes**, written peer-to-peer review is required. **Please complete section III.**
4. For all ages, is the patient receiving 2 or more different SNRIs (table 2) concurrently for greater than 60 days? ☐ YES ☐ NO
   - If **yes**, written peer-to-peer review is required. **Please complete section III.**
5. For all ages, is the patient receiving 2 or more different TCAs (table 3) concurrently for greater than 60 days? ☐ YES ☐ NO
   - If **yes**, written peer-to-peer review is required. **Please complete section III.**

PATIENT NAME:		MEDICAID ID:	

SECTION III: PEER-TO-PEER REVIEW

PLEASE NOTE:

- A written peer-to-peer review will be followed by a verbal peer-to-peer review with a health plan psychiatrist, medical director, or pharmacy director for approval if the written request is not approved.

(Provide any/all clinical rationale/justification for this request (i.e. documentation, chart notes, prior therapy, etc.)

☐ PEER-TO-PEER WRITTEN:

_____

_____

_____

_____

_____

☐ PEER-TO-PEER VERBAL

SECTION IV: RENEWAL CRITERIA

1.	Is the patient stable?	☐ YES	☐ NO
2.	Has the patient been seen by the prescribing provider within the past year?	☐ YES	☐ NO

SECTION V: NON-PREFERRED MEDICATION

Check the appropriate box and provide the required information for consideration of approval of the requested non-preferred medication.

☐ If there is <u>one</u> preferred agent in the preferred category, has the patient experienced an inadequate response after a trial of the preferred agent at a maximum tolerated dose, or do they have a documented intolerance or contraindication to the preferred agent?

☐ YES ☐ NO ☐ INTOLERANCE/CONTRAINDICATION

☐ If there are <u>two or more</u> agents in the preferred category, has the patient experienced an inadequate response after a trial of two or more of the preferred agents at their maximum tolerated dose, or do they have a documented intolerance or contraindication to two or more preferred agents?

☐ YES ☐ NO ☐ INTOLERANCE/CONTRAINDICATION

List previous medication trial and date(s) of trial:

- Medication Name: _____ Date(s) of trial: _____
- Medication Name: _____ Date(s) of trial: _____

List medication intolerance or contraindication (if any):

_____

_____

☐ An appropriate formulation or indication is not available as a preferred drug. Please specify which formulation or indication is needed and information supporting the need

- For formulation requests, please refer to the Non-Preferred PDL PA criteria to ensure specific requirements for oral, non-solid dosage forms are met (http://www.kdheks.gov/hcf/pharmacy/download/NonPreferred_PA_Criteria_for_PDL_Drugs.pdf)

_____

_____

PRESCRIBER SIGNATURE

☐ **I have completed all applicable boxes and attached any required documentation for review, in addition to signing and dating this form.**

_____ _____

Prescriber or authorized signature **Date**

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

TABLE 1. SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)

SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)
Citalopram (Celexa®)
Escitalopram (Lexapro®)
Fluoxetine (Prozac®, Prozac Weekly®)
Fluvoxamine (Luvox®, Luvox CR®)
Paroxetine (Paxil®, Paxil CR®, Pexeva®)
Sertraline (Zoloft®)

TABLE 2. SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)

SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)
Desvenlafaxine (Khedezla®, Pristiq®)
Duloxetine (Cymbalta®)
Levomilnacipran (Fetzima®)
Milnacipran (Savella®)
Venlafaxine (Effexor®, Effexor XR®)

TABLE 3. TRICYCLIC ANTIDEPRESSANTS (TCAS)

TRICYCLIC ANTIDEPRESSANTS (TCAS)
Amitriptyline
Amoxapine
Clomipramine (Anafranil®)
Desipramine (Norpramin®)
Doxepin
Imipramine (Tofranil®)
Imipramine Pamoate (Tofranil® PM)
Nortriptyline (Pamelor®)
Protriptyline (Vivactil®)
Trimipramine (Surmontil®)